

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

3660

**1. PLACE OF DEATH**

County Warren  
 Township Hickory Grove  
 City Wright City (No. ....)

Registration District No. 882  
 Primary Registration District No. 4535

File No. ....  
 Registered No. 3  
 St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. .... mos. .... ds. How long in U.S., if of foreign birth? yrs. .... mos. .... ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Male

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

married

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE~~**

Louise Grotewohl

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, .... hrs. or .... min.

77

11

9

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Warren Co Mo.

**10. NAME OF FATHER**

Don't Know

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Germany

**12. MAIDEN NAME OF MOTHER**

Don't Know

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Don't Know

PARENTS

**14.**

INFORMANT  
 (Address)

Louise B. Grotewohl  
Wright City, Mo.

**15.**

FILED

Jan 15, 1923  
Patricia Meier, Mo.  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

Jan 14<sup>th</sup> 1923

**17.**

HEREBY CERTIFY, That I attended deceased from Jan 4<sup>th</sup> 1923 to Jan 14<sup>th</sup> 1923 that I last saw him alive on Jan 13<sup>th</sup> 1923 and that death occurred, on the date stated above, at 1:50 A.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar Pneumonia

**CONTRIBUTORY (SECONDARY)**

Fracture of Hip (duration) yrs. .... mos. .... ds.  
fall (duration) yrs. .... mos. 10 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) M. J. Clarentsch M. D.

1/14 1923 (Address) Wright City Mo.

\*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

Removal to Lobar K's

Jan 16 1923

**20. UNDERTAKER**

ADDRESS

C. H. Nielburg

Wright City Mo.

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**NOTE.**—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Warren

Township \_\_\_\_\_

Village \_\_\_\_\_

City Wright City (No. \_\_\_\_\_)

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

882

4535

STANDARD CERTIFICATE OF DEATH

State of \_\_\_\_\_

Registered No. \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

August Graterwahl

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

M

6 DATE OF BIRTH

X February 23<sup>rd</sup> 1845  
(Month) (Day) (Year)

7 AGE

77 yrs. 11 mos. 11 ds.

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH

Jan 14 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Fracture of Hip, fall  
(Secondary) Caused by accidental fall

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) down stairway, M. D.

\_\_\_\_\_, 191\_\_\_\_ (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; add (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 15 yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

15

Filed

11-3184

REGISTRAR

Original filed Jan 15<sup>th</sup> 1923  
Duplicate filed March 25/23  
E. A. Thomsen M.D.

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